

PATIENTS WITHOUT DENTAL INSURANCE: Payment will be collected at your consultation appointment unless prior arrangements have been made through our third party lender, Care Credit.

PATIENTS WITH DENTAL INSURANCE: Any estimated co-payments, deductibles or services not covered by your insurance will be collected from you at your consultation appointment. Your insurance policy is a contract between you and your insurance company. (Please refer to your insurance company for any detailed policy questions). Verification of insurance coverage does not guarantee claim payment and any remaining balance on your account is your responsibility within 30 days of insurance claim submission. Any insurance over-payments will be refunded to you within 30 days of the last claim payment on your account.

INSTRUCTIONS FOR PATIENTS WITH DUAL DENTAL INSURANCE: We will collect your estimated co-payment based on your primary insurance. As a courtesy, we will file your claim to your secondary insurance once we receive the Explanation of Benefits from your primary insurance.

Please read the statements below and sign at the bottom of the page:

I understand that as a courtesy, a claim will be filed with my insurance carrier with associated forms and reports. I authorize the release of any information necessary to process this insurance claim. I authorize the payment of the applicable insurance benefits payable to me be made directly to San Antonio Endodontics or their providers. I understand that payment must be made at the time services are rendered unless prior arrangements are made.

I understand that I am responsible for the entire balance on my account, I am responsible for any fees the insurance company does not cover. I am also responsible for the cost of collection, as applicable. I understand that if San Antonio Endodontics has not received insurance claim payments within 30 days of the original filing (which may include up to two claim submissions). I will be responsible for paying the remaining balance on my account on the due date reflected on my statement. A \$50.00 fee will also be charged for any returned checks.

I understand that cancelling or rescheduling my appointment without a 48 hour notice is subject to a \$100.00 cancellation fee along with prepayment of copay to secure the future appointment date.

I understand and agree to the terms outlined in this financial policy.

Patient/parent/legal representative signature: _____ **Date:** _____